FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026237

Facility Name: GLENVIEW TERRACE NSG CTR

Address: 1511 GREENWOOD ROAD (Number) GLENVIEW (City) 60025 (Zip Code)

County: COOK

Telephone Number: (847) 729-9090 **Fax #** (847) 729-9135

IDPA ID Number: 362846112001

Date of Initial License for Current Owners: 11/01/75

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name:: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	295	Skilled (SNF)	295	107,675	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	295	TOTALS	295	107,675	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,248	21,099	10,862	53,209	8
9	SNF/PED					9
10	ICF	37,002	7,961	365	45,328	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	58,250	29,060	11,227	98,537	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.51%

D. How many bed-hold days during this year were paid by Public Aid?
359 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 65 and days of care provided 6007

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	351,120	148,110	5,560	504,790		504,790	4,912	509,702			1
2	Food Purchase		481,893		481,893	(66,430)	415,463	(2,106)	413,357			2
3	Housekeeping	408,030	85,444		493,474		493,474	15,107	508,581			3
4	Laundry	202,472	52,515		254,987		254,987		254,987			4
5	Heat and Other Utilities			254,409	254,409		254,409	4,438	258,847			5
6	Maintenance	53,752	46,085	80,439	180,276		180,276	4,370	184,646			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,015,374	814,047	340,408	2,169,829	(66,430)	2,103,399	26,721	2,130,120			8
	B. Health Care and Programs											
9	Medical Director			49,000	49,000		49,000		49,000			9
10	Nursing and Medical Records	4,065,828	189,484	10,080	4,265,392		4,265,392	(1,326)	4,264,066			10
10a	Therapy	316,698		(87)	316,611		316,611		316,611			10a
11	Activities	282,553	19,168	2,304	304,025		304,025		304,025			11
12	Social Services	185,398		2,400	187,798		187,798		187,798			12
13	Nurse Aide Training			1,000	1,000		1,000		1,000			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	4,850,477	208,652	64,697	5,123,826		5,123,826	(1,326)	5,122,500			16
	C. General Administration											
17	Administrative	323,523		570,000	893,523		893,523	(392,755)	500,768			17
18	Directors Fees											18
19	Professional Services			608,509	608,509		608,509	(466,926)	141,583			19
20	Dues, Fees, Subscriptions & Promotions			239,648	239,648		239,648	(186,255)	53,393			20
21	Clerical & General Office Expenses	235,976	9,101	151,482	396,559		396,559	108,744	505,303			21
22	Employee Benefits & Payroll Taxes			1,085,794	1,085,794	66,430	1,152,224	(63,959)	1,088,265			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,475	3,475		3,475	2,487	5,962			24
25	Other Admin. Staff Transportation			1,200	1,200		1,200		1,200			25
26	Insurance-Prop.Liab.Malpractice			155,567	155,567		155,567	(965)	154,602			26
27	Other (specify):*							52,284	52,284			27
28	**TOTAL General Administration**	559,499	9,101	2,815,675	3,384,275	66,430	3,450,705	(947,345)	2,503,360			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,425,350	1,031,800	3,220,780	10,677,930		10,677,930	(921,950)	9,755,980			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR #0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			245,838	245,838		245,838	(251)	245,587			30
31	Amortization of Pre-Op. & Org.			43,685	43,685		43,685	3,945	47,630			31
32	Interest			1,552,102	1,552,102		1,552,102	(1,402,360)	149,742			32
33	Real Estate Taxes			284,418	284,418		284,418	8,741	293,159			33
34	Rent-Facility & Grounds			284,101	284,101		284,101	(284,101)				34
35	Rent-Equipment & Vehicles			16,462	16,462		16,462	(3,613)	12,849			35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,426,606	2,426,606		2,426,606	(1,677,639)	748,967			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	316,218	386,522	261,072	963,812		963,812	(174,398)	789,414			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			161,513	161,513		161,513		161,513			42
43	Other (specify):*	76,240		19,544	95,784		95,784	(51,657)	44,127			43
44	**TOTAL Special Cost Centers**	392,458	386,522	442,129	1,221,109		1,221,109	(226,055)	995,054			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,817,808	1,418,322	6,089,515	14,325,645		14,325,645	(2,825,644)	11,500,001			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(691)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(99,115)	30		9
10	Interest and Other Investment Income	(332,791)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,415)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(66)	21		18
19	Entertainment				19
20	Contributions	(39,942)	20		20
21	Owner or Key-Man Insurance	(14,424)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(36,940)	21		24
25	Fund Raising, Advertising and Promotional	(160,087)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,529,892)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (2,215,363)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(610,281)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (610,281)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (2,825,644)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

GLENVIEW TERRACE NSG CTR

ID# 0026237

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Early Mortgage Payoff Penalty	$ (1,216,289)	32	1
2	Non-Allowable Auto Lease	(6,468)	35	2
3	Therapy Settlement	(174,398)	39	3
4	Veterans - Miscellaneous	(704)	10	4
5	Veterans - Pharmacy	(622)	10	5
6	Credit Card Fees	(15,294)	21	6
7	Trust Fees	(1,050)	21	7
8	Driver Salary & Gas Expense	(51,657)	43	8
9	Non-Care Auto Expense	(1,617)	30	9
10	Non-Allowable Legal Fees	(10,341)	19	10
11	Non-Care Auto Lease Insurance	(1,807)	26	11
12	Uncollectible Employee Loan	(49,535)	22	12
13	Seminar - Marketing	(110)	24	13
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary			4,912									4,912	1
2	Food Purchase	(2,106)											(2,106)	2
3	Housekeeping			15,107									15,107	3
4	Laundry													4
5	Heat and Other Utilities			4,438									4,438	5
6	Maintenance			4,370									4,370	6
7	Other (specify):*													7
8	**TOTAL General Services**	(2,106)		28,827									26,721	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(1,326)											(1,326)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(1,326)											(1,326)	16
	C. General Administration													
17	Administrative				41,849	(180,454)	(108,490)	(145,660)					(392,755)	17
18	Directors Fees													18
19	Professional Services	(10,341)		(384,654)	(73,124)	1,164		29					(466,926)	19
20	Fees, Subscriptions & Promotions	(200,029)		1,888	11,882			4					(186,255)	20
21	Clerical & General Office Expenses	(53,350)		156,385	3,704	715	1,287	3					108,744	21
22	Employee Benefits & Payroll Taxes	(63,959)											(63,959)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(110)		2,554	43								2,487	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice	(1,807)		842									(965)	26
27	Other (specify):*			41,487	7,339	1,455	1,855	148					52,284	27
28	**TOTAL General Administration**	(329,596)		(181,498)	(8,307)	(177,120)	(105,348)	(145,476)					(947,345)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(333,028)		(152,671)	(8,307)	(177,120)	(105,348)	(145,476)					(921,950)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 **Report Period Beginning:** 01/01/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(100,732)	75,010	25,460				11					(251)	30
31	Amortization of Pre-Op. & Org.		3,674	271									3,945	31
32	Interest	(1,549,080)	107,890	38,830									(1,402,360)	32
33	Real Estate Taxes			8,741									8,741	33
34	Rent-Facility & Grounds		(284,101)										(284,101)	34
35	Rent-Equipment & Vehicles	(6,468)		2,855									(3,613)	35
36	Other (specify):*													36
37	**TOTAL Ownership**	(1,656,280)	(97,527)	76,157				11					(1,677,639)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers	(174,398)											(174,398)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(51,657)											(51,657)	43
44	**TOTAL Special Cost Centers**	(226,055)											(226,055)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(2,215,363)	(97,527)	(76,514)	(8,307)	(177,120)	(105,348)	(145,465)					(2,825,644)	45

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Glenview Realty		Building Prtnship.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 284,101	Glenview Realty	100.00%	$	$ (284,101)	1
2	V	30	Depreciation		Glenview Realty	100.00%	75,010	75,010	2
3	V	31	Amortization		Glenview Realty	100.00%	3,674	3,674	3
4	V	32	Interest		Glenview Realty	100.00%	107,890	107,890	4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 284,101			$ 186,574	$ * (97,527)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	$	ITEX MGMT. / A.K. CARE	100.00%	$ 4,912	$ 4,912	15
16	V	3	HOUSEKEEPING		ITEX MGMT. / A.K. CARE	100.00%	15,107	15,107	16
17	V	5	UTILITIES		ITEX MGMT. / A.K. CARE	100.00%	4,438	4,438	17
18	V	6	REPAIRS AND MAINT.		ITEX MGMT. / A.K. CARE	100.00%	4,370	4,370	18
19	V	19	PROFESSIONAL FEES		ITEX MGMT. / A.K. CARE	100.00%	9,721	9,721	19
20	V	20	FEES, SUBSCRIPTIONS		ITEX MGMT. / A.K. CARE	100.00%	1,888	1,888	20
21	V	21	CLERICAL AND GENERAL		ITEX MGMT. / A.K. CARE	100.00%	30,872	30,872	21
22	V	24	EDUCATION/SEMINARS		ITEX MGMT. / A.K. CARE	100.00%	2,554	2,554	22
23	V	26	INSURANCE		ITEX MGMT. / A.K. CARE	100.00%	842	842	23
24	V	27	EMPLOYEE BENEFITS		ITEX MGMT. / A.K. CARE	100.00%	1,651	1,651	24
25	V	30	DEPRECIATION		ITEX MGMT. / A.K. CARE	100.00%	25,460	25,460	25
26	V	31	AMORTIZATION		ITEX MGMT. / A.K. CARE	100.00%	271	271	26
27	V	32	INTEREST		ITEX MGMT. / A.K. CARE	100.00%	38,830	38,830	27
28	V	33	REAL ESTATE TAXES		ITEX MGMT. / A.K. CARE	100.00%	8,741	8,741	28
29	V	35	EQUIPMENT RENTAL		ITEX MGMT. / A.K. CARE	100.00%	2,855	2,855	29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX MGMT. / A.K. CARE	100.00%	125,513	125,513	32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX MGMT. / A.K. CARE	100.00%	39,836	39,836	33
34	V								34
35	V	19	HOME OFFICE	394,375	ITEX MGMT. / A.K. CARE	100.00%		(394,375)	35
36	V								36
37	V								37
38	V								38
39	Total			$ 394,375			$ 317,861	$ * (76,514)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	CAREPATH HEALTH NETWORK	100.00%	$ 41,849	$ 41,849	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	1,468	1,468	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	11,882	11,882	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	3,704	3,704	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	43	43	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	7,339	7,339	20
21	V								21
22	V								22
23	V								23
24	V	19	HOME OFFICE	74,592	CAREPATH HEALTH NETWORK	100.00%		(74,592)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 74,592			$ 66,285	$ * (8,307)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	BERNIE HOLLANDER-SAL.	$	SHAYMARK MANAGEMENT CORP.	100.00%	$ 29,546	$ 29,546	15
16	V	19	PROFESSIONAL FEES		SHAYMARK MANAGEMENT CORP.	100.00%	1,164	1,164	16
17	V	21	OFFICE		SHAYMARK MANAGEMENT CORP.	100.00%	715	715	17
18	V	27	PAYROLL TAXES		SHAYMARK MANAGEMENT CORP.	100.00%	1,455	1,455	18
19	V								19
20	V								20
21	V								21
22	V	17	MANAGEMENT FEES	210,000	SHAYMARK MANAGEMENT CORP.	100.00%		(210,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 210,000			$ 32,880	$ * (177,120)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	J. RAJCHENBACH-COMP.	$	JLR MANAGEMENT CORP.	100.00%	$ 41,510	$ 41,510	15
16	V	21	OFFICE		JLR MANAGEMENT CORP.	100.00%	1,287	1,287	16
17	V	27	PAYROLL TAXES		JLR MANAGEMENT CORP.	100.00%	1,855	1,855	17
18	V								18
19	V								19
20	V								20
21	V	17	MARVIN NEEDLE-CONS. FEES		JLR MANAGEMENT CORP.	100.00%			21
22	V								22
23	V								23
24	V	17	MARK BERGER-CONS. FEES		JLR MANAGEMENT CORP.	100.00%			24
25	V	21	SECRETARIAL		JLR MANAGEMENT CORP.	100.00%			25
26	V								26
27	V								27
28	V								28
29	V	17	MANAGEMENT FEES	150,000	JLR MANAGEMENT CORP.	100.00%		(150,000)	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 150,000			$ 44,652	$ * (105,348)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	INTERCARE, LTD.	100.00%	$ 4,340	$ 4,340	15
16	V	19	PROFESSIONAL FEES		INTERCARE, LTD.	100.00%	29	29	16
17	V	20	FEES, SUBSCRIPTIONS		INTERCARE, LTD.	100.00%	4	4	17
18	V	21	CLERICAL & GENERAL		INTERCARE, LTD.	100.00%	3	3	18
19	V	27	EMPLOYEE BENEFITS		INTERCARE, LTD.	100.00%	148	148	19
20	V	30	DEPRECIATION		INTERCARE, LTD.	100.00%	11	11	20
21	V								21
22	V	17	MANAGEMENT FEES	150,000	INTERCARE, LTD.	100.00%		(150,000)	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 150,000			$ 4,535	$ * (145,465)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bernard Hollander	Owner	Administrative	18.06%	See Attached	10	15.38%	Shaymark	$ 29,546	17 - 07	1
2	Yosef Davis	Owner	Administrative	8.24%	See Attached	1	1.60%	InterCare	4,340	17 - 07	2
3	Jack Rajchenbach	Owner	Administrative	9.80%	See Attached	15	23.07%	JLR Mgmt	41,510	17 - 07	3
4	Mark Hollander	Relative	Administrative	0.00%	See Attached	5	8.33%	Salary	149,424	17 - 01	4
5								Mgmt. Fees	60,000	17 - 03	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 284,820		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: ITEX COMPANY
Street Address: 6633 N. LINCOLN AVE.
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAIL. BED DAYS	462,455	5	$ 21,096	$	107,675	$ 4,912	1
2	3	HOUSEKEEPING	AVAIL. BED DAYS	462,455	5	64,883		107,675	15,107	2
3	5	UTILITIES	AVAIL. BED DAYS	462,455	5	19,061		107,675	4,438	3
4	6	REPAIRS AND MAINT.	AVAIL. BED DAYS	462,455	5	18,769		107,675	4,370	4
5	19	PROFESSIONAL FEES	AVAIL. BED DAYS	462,455	5	41,751		107,675	9,721	5
6	20	FEES, SUBSCRIPTIONS	AVAIL. BED DAYS	462,455	5	8,107		107,675	1,888	6
7	21	CLERICAL AND GENERAL	AVAIL. BED DAYS	462,455	5	132,593		107,675	30,872	7
8	24	EDUCATION/SEMINARS	AVAIL. BED DAYS	462,455	5	10,970		107,675	2,554	8
9	26	INSURANCE	AVAIL. BED DAYS	462,455	5	3,618		107,675	842	9
10	27	EMPLOYEE BENEFITS	AVAIL. BED DAYS	462,455	5	7,090		107,675	1,651	10
11	30	DEPRECIATION	AVAIL. BED DAYS	462,455	5	109,347		107,675	25,460	11
12	31	AMORTIZATION	AVAIL. BED DAYS	462,455	5	1,165		107,675	271	12
13	32	INTEREST	AVAIL. BED DAYS	462,455	5	166,773		107,675	38,830	13
14	33	REAL ESTATE TAXES	AVAIL. BED DAYS	462,455	5	37,542		107,675	8,741	14
15	35	EQUIPMENT RENTAL	AVAIL. BED DAYS	462,455	5	12,263		107,675	2,855	15
16										16
17										17
18	21	CLERICAL SALARIES	AVAIL. BED DAYS		5	708,007	708,007		125,513	18
19	27	GEN ADMIN. - EMP. BEN.	AVAIL. BED DAYS		5	224,712			39,836	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,587,747	$ 708,007		$ 317,861	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	629,760	13	$ 353,316	$ 353,316	74,592	$ 41,849	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	629,760	13	12,396		74,592	1,468	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	629,760	13	100,317		74,592	11,882	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	629,760	13	31,275		74,592	3,704	4
5	24	SEMINARS	CARE PATH FEES	629,760	13	366		74,592	43	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	629,760	13	61,960		74,592	7,339	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 559,630	$ 353,316		$ 66,285	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: SHAYMARK MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	BERNIE HOLLANDER-SAL.	AVG. HRS. WORKED	53	5	$ 156,596	$ 156,596	10	$ 29,546	1
2	19	PROFESSIONAL FEES	AVG. HRS. WORKED	53	5	6,170		10	1,164	2
3	21	OFFICE	AVG. HRS. WORKED	53	5	3,790	3,790	10	715	3
4	27	PAYROLL TAXES	AVG. HRS. WORKED	53	5	7,708		10	1,455	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 174,264	$ 160,386		$ 32,880	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: JLR MANAGEMENT CORP.
Street Address: 6633 NORTH LINCOLN
City / State / Zip Code: LINCOLNWOOD, IL. 60712
Phone Number: (847) 679-9141
Fax Number: (847) 679-1820

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	J. RAJCHENBACH-COMP.	AVG. HRS. WORKED	61	9	$ 168,808	$ 168,808	15	$ 41,510	1
2	21	OFFICE	AVG. HRS. WORKED	61	9	5,235		15	1,287	2
3	27	PAYROLL TAXES	AVG. HRS. WORKED	61	9	7,543		15	1,855	3
4										4
5										5
6										6
7	17	MARVIN NEEDLE-CONS. FEES	AVG. HRS. WORKED	40	1	36,296				7
8										8
9										9
10	17	MARK BERGER-CONS. FEES	AVG. HRS. WORKED	50	2	10,000				10
11	21	SECRETARIAL	AVG. HRS. WORKED	50	2	5,000				11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 232,882	$ 168,808		$ 44,652	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: INTERCARE, LTD.
Street Address: 3553 W. PETERSON AVE. 3RD FLOOR
City / State / Zip Code: CHICAGO, IL. 60659
Phone Number: (773) 463-1313
Fax Number: (773) 463- 5311

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	AVG. HRS. WORKED	60	6	$ 260,400	$ 260,400	1	$ 4,340	1
2	19	PROFESSIONAL FEES	AVG. HRS. WORKED	60	6	1,715		1	29	2
3	20	FEES, SUBSCRIPTIONS	AVG. HRS. WORKED	60	6	218		1	4	3
4	21	CLERICAL & GENERAL	AVG. HRS. WORKED	60	6	178		1	3	4
5	27	EMPLOYEE BENEFITS	AVG. HRS. WORKED	60	6	8,871		1	148	5
6	30	DEPRECIATION	AVG. HRS. WORKED	60	6	678		1	11	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 272,060	$ 260,400		$ 4,535	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Mid-North Financial		X	Mortgage	$64,018	09/01/88	$ 4,500,000	$		10.63%	$ 1,417,769	1
2	Toyota Motor Credit		X	Auto Loan	$1,111	12/01/99	35,318			8.25%	687	2
3	IFC Credit Corp		X	Telephone System	$463	03/01/01	24,125	21,024	02/01/06	5.66%	1,062	3
4			X	Mortgage		10/15/01		8,154,127			107,891	4
5												5
	Working Capital											
6	American National Bank		X	Line of Credit				800,000		4.75%	128,392	6
7												7
8												8
9	TOTAL Facility Related				$65,592		$ 4,559,443	$ 8,975,151			$ 1,655,801	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(1,510,250)	10
11	MONY Life Insurance		X	CSV Life Insurance Interest							419	11
12	INAC		X	Insurance Financing							3,720	12
13	Miscellaneous										52	13
14	TOTAL Non-Facility Related						$	$			$ (1,506,059)	14
15	TOTALS (line 9+line14)						$ 4,559,443	$ 8,975,151			$ 149,742	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Alloc. - Itex Mgmt. / A.K. Care	X					$	$			$ 38,830	1
2												2
3	Mid-North Financial		X	Early Mortgage Payoff Penalty							(1,216,289)	3
4	Interest Income										(332,791)	4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (1,510,250)	21

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 279,757	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 283,948	2
3. Under or (over) accrual (line 2 minus line 1).		$ 4,191	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 288,968	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 293,159	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	221,268	8
	1997	224,164	9
	1998	265,042	10
	1999	266,436	11
	2000	275,207	12

Real Estate Tax Accrual = $275,207 8 1.05 = $288,968

Allocation Item Mgmt. / A.K. Care = $8,741

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENVIEW TERRACE NSG CTR COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0026237

CONTACT PERSON REGARDING THIS REPORT STEVE LAVENDA

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-28-401-042-0000	Nursing Home	$ 275,207.68	$ 275,207.68
2.	10-35-329-014-0000	Central Office	$ 37,542.26	$ 8,741.10
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 312,749.94	$ 283,948.78

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 79,000 B. General Construction Type: Exterior Brick Frame Steel and Concrete Number of Stories Three

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 611,148
2. Number of Years Over Which it is Being Amortized: 20, 42
3. Current Period Amortization: 47,630
4. Dates Incurred: 1988, 2001

Nature of Costs: Loan Costs = $43,685, Glenview Realty = $3,674, Itex Mgmt. / A.K. Care = $271
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1978	$ 167,502	1
2					2
3	TOTALS			$ 167,502	3

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	253			1978	$ 2,750,940	$ 108,719	35	$ 68,774	$ (39,945)	$ 1,744,260	4
5				1989	1,453,936	48,763	35	36,348	(12,415)	442,872	5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1975	28,890		20	-		28,890	9
10	Various			1977	11,520		20	-		6,484	10
11	Various			1978	1,209		20	-		1,209	11
12	Various			1979	4,832		20	-		4,832	12
13	Various			1980	6,097		20	-		6,097	13
14	Various			1981	2,004		20	96	96	1,610	14
15	Various			1982	6,604		20	330	330	2,640	15
16	Various			1983	5,607		20	1	1	5,607	16
17	Various			1984	4,233		20	-		4,233	17
18	Various			1985	10,997		20	456	456	7,652	18
19	Various			1986	2,080		20	104	104	1,560	19
20	Various			1987	2,375		20	119	119	952	20
21	Various			1988	4,955		20	248	248	2,455	21
22	Various			1989	111,464		20	5,574	5,574	63,477	22
23	Various			1990	98,033		20	4,903	4,903	44,286	23
24	Various			1991	2,229		20	111	111	959	24
25	Various			1992	3,024		20	151	151	1,304	25
26	Various			1993	103,239		20	5,163	5,163	44,989	26
27	Various			1994	23,033		20	1,152	1,152	7,859	27
28	Various			1995	44,266		20	2,214	2,214	14,206	28
29	Various			1996	93,171		20	4,659	4,659	25,973	29
30	Various			1997	102,244		20	3,753	3,753	16,994	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		458,396	11,656		14,915	3,259	124,398	68
69	Financial Statement Depreciation			21,748			(21,748)		69
70	TOTAL (lines 4 thru 69)		$ 5,335,378	$ 190,886		$ 149,071	$ (41,815)	$ 2,605,798	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 5,335,378	$ 190,886		$ 149,071	$ (41,815)	$ 2,605,798	1
2	1ST FLR OFFICE DOOR	1998	670		20	34	34	102	2
3	ELECTRICAL REPAIRS	1998	1,938		20	97	97	291	3
4	CHANGE LOCKS	1998	1,012		20	51	51	153	4
5	DOOR ANSWERING SYSTE	1998	1,012		20	51	51	153	5
6	COMMUNICATION	1998	542		20	27	27	81	6
7	PHONE & DOOR UNIT	1998	792		20	40	40	120	7
8	AIR COND REPAIRS	1998	900		20	45	45	135	8
9	2 SMOKE DAMPERS	1998	3,357		20	168	168	630	9
10	CAULKING WINDOWS	1998	2,590		20	130	130	498	10
11	MORTON FLOOR	1998	1,900		20	95	95	364	11
12	PATIO	1998	11,024		20	551	551	2,020	12
13	FIRE DAMPER	1998	9,559		20	478	478	1,872	13
14	SCUPPERS & DONNS	1998	2,490		20	125	125	469	14
15	FIRE DAMPERS	1998	1,553		20	78	78	280	15
16	SU-BASE IN SHOWERS	1998	3,610		20	181	181	588	16
17	SMOKE & FIRE DAMPERS	1998	11,070		20	554	554	1,708	17
18	FIRE DAMPERS	1998	4,927		20	246	246	779	18
19	PATIO DOORS	1998	8,402		20	420	420	1,435	19
20	ROOF	1998	7,950		20	398	398	1,260	20
21	FIRE DAMPERS	1998	3,450		20	173	173	606	21
22	FIRE DAMPERS	1998	1,760		20	88	88	293	22
23	HEAT EXCHANGER	1998	4,965		20	476	476	1,428	23
24	WALLCOVERING	1998	3,852		20	372	372	1,116	24
25	WALK IN COOLER	1998	2,950		20	286	286	858	25
26	ELEVATOR DOOR CROUD	1998	1,360		20	133	133	399	26
27	SODIUM FIXTURES	1998	3,500		20	338	338	1,014	27
28	CABLES FOR MODEM	1998	997		20	96	96	288	28
29	VERTICAL TRAUSS	1998	3,879		20	385	385	1,155	29
30	SECURITY CAMERA	1998	1,378		20	136	136	408	30
31	WINDOW TREATMENT	1999	3,749		20	375	375	813	31
32	SHELVING	1999	835		20	42	42	88	32
33	PLUMBING	1999	885		20	44	44	92	33
34	TOTAL (lines 1 thru 33)		$ 5,444,236	$ 190,886		$ 155,784	$ (35,102)	$ 2,627,294	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 5,444,236	$ 190,886		$ 155,784	$ (35,102)	$ 2,627,294	1
2	WINDOW LEDGES	1999	500		20	25	25	52	2
3	ELECTRICAL	1999	550		20	28	28	58	3
4	HEATING UNITS	1999	4,600		20	230	230	690	4
5	ALARM SYSTEM	1999	7,137		20	357	357	1,071	5
6	SMOKE & FIRE DAMPERS	1999	2,298		20	115	115	345	6
7	MIRROR WALL-PT ROOM	1999	1,526		20	76	76	222	7
8	WALLCOVERING	1999	1,357		20	136	136	397	8
9	IN RPO CORP	1999	9,217		20	461	461	1,268	9
10	WALL FIXTURES	1999	1,815		20	91	91	250	10
11	METAL DOOR FRAMES	1999	5,599		20	280	280	770	11
12	CUSTOM BELLBOARD	1999	3,160		20	158	158	421	12
13	WINDOWS	1999	1,431		20	72	72	192	13
14	NEW WOOD DOORS	1999	11,792		20	590	590	1,524	14
15	DOOR LOCKS -NEW DOOR	1999	8,291		20	415	415	1,072	15
16	LANDCAPE IMPROV	1999	6,368		20	318	318	795	16
17	RE-ROOF	1999	1,950		20	98	98	237	17
18	WINDOW SCREENS	1999	1,864		20	93	93	225	18
19	SOUND SYSTEM	1999	793		20	79	79	165	19
20	WALLCOVERING	1999	990		20	99	99	281	20
21	WALLCOVERING	1999	3,892		20	389	389	1,135	21
22	A/C COMPRESSOR	1999	1,400		20	140	140	362	22
23	CARPETING	1999	20,225		20	2,023	2,023	5,732	23
24	TILEWORK	1999	17,358		20	1,736	1,736	4,629	24
25	CARPETING	1999	10,112		20	1,011	1,011	2,696	25
26	DRAPERY	1999	3,211		20	321	321	829	26
27	WALLCOVERING	1999	8,678		20	868	868	2,387	27
28	CARPETING	1999	3,601		20	360	360	960	28
29	WALLCOVERING	1999	3,735		20	374	374	1,060	29
30	WINDOW DRAPES	1999	895		20	90	90	218	30
31	LIGHT FIXTURES	1999	1,144		20	114	114	304	31
32	WALL BASE	2000	767		20	38	38	67	32
33	CEILING TILE	2000			20				33
34	TOTAL (lines 1 thru 33)		$ 5,590,492	$ 190,886		$ 166,969	$ (23,917)	$ 2,657,708	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 5,590,492	$ 190,886		$ 166,969	$ (23,917)	$ 2,657,708	1
2	HEAT EXHANGER REPL	2000	3,700		20	185	185	247	2
3	PATIENT ALARM SYSTEM	2000	17,946		20	897	897	897	3
4	PATIENT ALARM SYSTEM	2000	5,202		20	260	260	347	4
5	WALL COVERING	2000	761		20	38	38	89	5
6	WALL COVERINGS	2000	1,588		20	79	79	185	6
7	WALL COVERING	2000	2,291		20	115	115	210	7
8	VERTICAL TRACKS & VA	2000	2,437		20	122	122	163	8
9	WINDOE REGLAZING	2000	513		20	26	26	26	9
10	CEILING TILE	2000	1,993		20	199	199	241	10
11	PAVING	2001	4,893		20	184	184	184	11
12	PAVING	2001	4,050		20	152	152	152	12
13	FIXURES	2001	920		20	31	31	31	13
14	ROOF	2001	94,000		20	3,133	3,133	3,133	14
15	ROOF	2001	7,400		20	247	247	247	15
16	TELEPHONE SYSTEM	2001	24,275		20	1,012	1,012	1,012	16
17	VIDEO SURVEILLANCE	2001	3,941		20	164	164	164	17
18	VIDEO CAMERA	2001	656		20	22	22	22	18
19	VANES & TRACKS	2001	1,495		20	50	50	50	19
20	WALLCOVERING	2001	3,699		20	185	185	185	20
21	CARPET	2001	2,674		20	134	134	134	21
22	DRAPERIES & CORNICES	2001	2,764		20	138	138	138	22
23	CURTAINS	2001	1,918		20	96	96	96	23
24	DRAPERY	2001	1,375		20	69	69	69	24
25	BORDER & TRACK SETS	2001	394		20	12	12	12	25
26	SHADES,LIGHTS&BORDER	2001	1,663		20	42	42	42	26
27	CUBILE CURTAINS & TR	2001	3,596		20	90	90	90	27
28	CUBICLE & SHADES	2001	3,224		20	54	54	54	28
29	WALLCOVERING	2001	8,642		20	144	144	144	29
30	PAINT	2001	513		20	24	24	24	30
31	TOILET RAILS	2001	585		20	27	27	27	31
32	CEILING TILE	2001	689		20	31	31	31	32
33	TOILETS & FRAMES	2001	852		20	25	25	25	33
34	TOTAL (lines 1 thru 33)		$ 5,801,141	$ 190,886		$ 174,956	$ (15,930)	$ 2,666,179	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,801,141	$ 190,886		$ 174,956	$ (15,930)	$ 2,666,179	1
2	TRANSMITTERS	2001	679		20	28	28	28	2
3	TRANSMITTERS	2001	657		20	6	6	6	3
4	LOCKS	2001	529		20	2	2	2	4
5	CEILING TILE	2001	589		20	2	2	2	5
6	CEILING TILE	2001	601		20	3	3	3	6
7	PAVEMENT	2001	2,065		20	94	94	94	7
8	WATER COIL	2001	685		20	26	26	26	8
9	AC COMPRESSOR	2001	675		20	23	23	23	9
10	PIPE REROUT	2001	660		20	22	22	22	10
11	AC COMPRESSOR	2001	850		20	18	18	18	11
12	VALVE REPLACEMENT	2001	510		20	7	7	7	12
13	WALLCOVERINGS	2001	5,353		20	22	22	22	13
14	DRAPERY & CUB TRACKS	2001	29,406		20	123	123	123	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,844,400	$ 190,886		$ 175,332	$ (15,554)	$ 2,666,555	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1993		$ 373,477	$ 9,576	35	$ 10,671	$ 1,095	$ 91,590	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation Itex Mgmt. / A.K. Care			1993	46,994	567	20	2,351	1,784	20,457	9
10	Allocation Itex Mgmt. / A.K. Care			1994	25,242	919	20	1,262	343	9,190	10
11	Allocation Itex Mgmt. / A.K. Care			1995	4,302	355	20	215	(140)	1,333	11
12	Allocation Itex Mgmt. / A.K. Care			1996	244	21	20	12	9	73	12
13	Allocation Itex Mgmt. / A.K. Care			1997	7,257	186	20	363	177	1,633	13
14	Allocation Itex Mgmt. / A.K. Care			1999	806	21	20	40	19	121	14
15											15
16	Allocation InterCare			2001	74	11	20	1	(10)	1	16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 458,396	$ 11,656		$ 14,915	$ 3,277	$ 124,398	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,159,402	$ 68,299	$ 50,798	$ (17,501)	10	$ 808,225	71
72	Current Year Purchases	161,021	71,920	6,180	(65,740)	10	6,180	72
73	Fully Depreciated Assets	564,358	1	1		10	564,358	73
74								74
75	TOTALS	$ 1,884,781	$ 140,220	$ 56,979	$ (83,241)		$ 1,378,763	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1992-FORD VAN	1992	$ 24,679	$ 1,575	$	$ (1,575)	5	$ 19,260	76
77	FACILITY	DODGE 96 RAM WAGON	1996	26,400	1,775	440	(1,335)	5	14,900	77
78	FACILITY	1998 DODGE / CHEVY EXPRES	1998	48,756	8,913	7,836	(1,077)	5	16,796	78
79	FACILITY	LANDCRUISER	1999	25,000	1,333	5,000	3,667	5	8,643	79
80	TOTALS			$ 124,835	$ 13,596	$ 13,276	$ (320)		$ 59,599	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$	8,021,518	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$	344,702	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$	245,587	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	(99,115)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$	4,104,917	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	EXCESS AUTO COST - 1999	$ 30,318	$ 1,617	$ 1,617	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 30,318	$ 1,617	$ 1,617	91

G. Construction-in-Progress

	Description	Cost	
92	Building	$ 2,149,084	92
93			93
94			94
95		$ 2,149,084	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [ ] NO

16. Rental Amount for movable equipment: $ 12,849 Description: Water Cooler = $600, Pitney Bowes = $3,037, Copy Machine = $6,357, Alloc. Itex Mgmt. = $2,855
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrator	1999 Lexus RX 300	$ 539	$ 6,468	17
18	Non-Allowable			(6,468)	18
19					19
20					20
21	TOTAL		$ 539	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		1,000		1,000
9	TOTALS	$	$ 1,000	$	$ 1,000
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,000			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	26
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	27

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 01	hrs	$ 75,452		$ 80,932	$		$ 156,384	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	14,889		13,054			27,943	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	158,673		167,086			325,759	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				338,009		338,009	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):			67,204			48,513		115,717	13
14	TOTAL			$ 316,218		$ 261,072	$ 386,522		$ 963,812	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 12,186	$ 12,186	1
2	Cash-Patient Deposits	30,407	30,407	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,981,544	1,981,544	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	309,035	309,035	6
7	Other Prepaid Expenses	18,879	18,879	7
8	Accounts Receivable (owners or related parties)	5,602,218	5,602,218	8
9	Other(specify): See supplemental schedule	58,374	98,733	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 8,012,643	$ 8,053,002	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		198,820	13
14	Buildings, at Historical Cost		4,797,602	14
15	Leasehold Improvements, at Historical Cost		772,020	15
16	Equipment, at Historical Cost	267,296	2,268,456	16
17	Accumulated Depreciation (book methods)	(71,561)	(5,291,383)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		611,148	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(3,675)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule	434,201	2,583,285	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 629,936	$ 5,936,273	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,642,579	$ 13,989,275	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 955,576	$ 955,579	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	36,128	36,128	28
29	Short-Term Notes Payable	804,503	804,503	29
30	Accrued Salaries Payable	409,252	409,252	30
31	Accrued Taxes Payable (excluding real estate taxes)	29,697	29,697	31
32	Accrued Real Estate Taxes(Sch.IX-B)	288,968	288,968	32
33	Accrued Interest Payable	2,471	96,988	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	5,671,646	47,385	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,198,241	$ 2,668,500	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	16,521	16,521	39
40	Mortgage Payable		8,154,127	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 16,521	$ 8,170,648	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,214,762	$ 10,839,148	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 427,817	$ 3,150,127	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,642,579	$ 13,989,275	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,893,167	1	
2	Restatements (describe):		2	
3	**Rounding Adjustment**	(1)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,893,166	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(230,144)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(3,235,205)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (3,465,349)	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 427,817	24	*

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 13,056,520	1
2	Discounts and Allowances for all Levels	(1,666,781)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 11,389,739	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,623,389	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,623,389	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	60	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	691	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	422,563	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	87,329	19
20	Radiology and X-Ray		20
21	Other Medical Services	26,104	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 536,747	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	332,791	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 332,791	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	212,835	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 212,835	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 14,095,501	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,169,829	31
32	Health Care	5,123,826	32
33	General Administration	3,384,275	33
	B. Capital Expense		
34	Ownership	2,426,606	34
	C. Ancillary Expense		
35	Special Cost Centers	1,059,596	35
36	Provider Participation Fee	161,513	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 14,325,645	40
41	**Income before Income Taxes (line 30 minus line 40)****	(230,144)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (230,144)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,037	2,454	$ 145,338	$ 59.22	1
2	Assistant Director of Nursing	1,032	1,280	34,341	26.83	2
3	Registered Nurses	40,995	52,578	1,155,628	21.98	3
4	Licensed Practical Nurses	22,385	26,969	524,322	19.44	4
5	Nurse Aides & Orderlies	186,257	208,426	1,850,713	8.88	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	10,017	11,063	316,218	28.58	7
8	Rehab/Therapy Aides	20,991	23,503	316,698	13.47	8
9	Activity Director	1,800	2,233	29,186	13.07	9
10	Activity Assistants	30,457	32,404	253,367	7.82	10
11	Social Service Workers	15,648	17,075	185,398	10.86	11
12	Dietician					12
13	Food Service Supervisor	1,827	2,086	52,163	25.01	13
14	Head Cook	2,045	2,274	22,995	10.11	14
15	Cook Helpers/Assistants	32,967	36,247	275,962	7.61	15
16	Dishwashers					16
17	Maintenance Workers	2,549	2,938	53,752	18.30	17
18	Housekeepers	49,724	53,518	408,030	7.62	18
19	Laundry	23,574	25,699	202,472	7.88	19
20	Administrator	1,917	2,286	157,069	68.71	20
21	Assistant Administrator	750	800	17,030	21.29	21
22	Other Administrative	260	260	149,424	574.71	22
23	Office Manager	2,036	2,547	49,512	19.44	23
24	Clerical	9,941	11,732	186,464	15.89	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	28,758	31,865	355,486	11.16	31
32	Other Health Care(specify)					32
33	Other(specify)	6,184	6,389	76,240	11.93	33
34	TOTAL (lines 1 - 33)	494,151	556,626	$ 6,817,808 *	$ 12.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 5,560	01-03	35
36	Medical Director	Monthly	49,000	09-03	36
37	Medical Records Consultant	Monthly	4,032	10-03	37
38	Nurse Consultant		(450)	10-03	38
39	Pharmacist Consultant	Monthly	6,498	10-03	39
40	Physical Therapy Consultant		(300)	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	4	213	10a-03	43
44	Activity Consultant	Monthly	2,304	11-03	44
45	Social Service Consultant	Monthly	2,400	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	4	$ 69,257		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Fred Berkovits	Administrator	0	$ 157,069
Yoni Safirstejn	Asst. Admin.	0	17,030
Mark Hollander	Executive	0	149,424
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 323,523

B. Administrative - Other

Description	Amount
Management Fees - Shaymark	$ 210,000
Management Fees - Intercare, Ltd.	150,000
Management Fees - JLR Management	150,000
Management Fees - Mark Hollander	60,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 570,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
A.K. Care	Accounting/Data Processing	$ 394,375
CarePath	Accounting	74,592
Healthcare Horizons	Admin. Consultant	8,360
Power Software	Data Processing	18,229
LTC Solution	Data Processing	1,288
Gibson Tech	Data Processing	375
Purchasing Plus	Purchasing Consultant	600
Personnel Planners	Unemployment Consultant	1,190
Susan Fox	Accounting	14,940
Frost, Ruttenberg, & Rothblatt	Accounting	39,263
Comittment Consulting	Accounting	23,873
See Attached	Legal, Appraisal, Accred.	31,425
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 608,509

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 106,432
Unemployment Compensation Insurance	36,158
FICA Taxes	505,401
Employee Health Insurance	281,853
Employee Meals	66,430
Illinois Municipal Retirement Fund (IMRF)*	
Pension Contributions	72,007
Life Insurance	1,413
Christmas Expense	12,197
Miscellaneous Employee Benefits	6,374
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,088,265

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	7,881
Health Care Worker Background Check	
(Indicate # of checks performed 30)	300
Recruitment Fee	13,000
Advertising and Public Relations	160,087
Associated Dues	11,099
Dues and Subscriptions	6,298
Licenses	1,041
Alloc: Item Mgmt/CarePath/InterCare	13,774
Less: Public Relations Expense	(82,794)
Non-allowable advertising	(77,293)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 53,393

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,475
Allocation - Itex Mgmt. / A.K. Care	2,554
Allocation - CarePath	43
Non-Allowable - Marketing	(110)
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,962

* Attach copy of IMRF notifications

**See instructions.

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number GLENVIEW TERRACE NSG CTR # 0026237 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **ICLTC = $18,230**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **11,349** Line **10 - 02**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **161,513**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **N/A** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **66,430** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **691**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees